CHILD STUDY & TREATMENT CENTER
Mental Health Division, Department of Social and Health Services
State of Washington

Scope of Services

January 2008

CSTC will strive to provide the highest quality standard of care treatment for our patients and families. Our clinical programs will work to adopt, develop and implement effective interventions for youth with serious emotional and behavioral disorders. Treatment planning and scope of services will be guided by evidence based research, and national best practice guidelines, including the American Academy of Child and Adolescent Psychiatry's Practice Parameters, and reviews of evidence based psychotherapies compiled by the American Psychological Association.

Children and adolescents at CSTC often present with multiple overlapping syndromes, plus confounding issues such as family turmoil, abuse and neglect, and/or involvement with social welfare/juvenile justice systems. Diagnostic and psychosocial comorbidity greatly complicate treatment planning. We are challenged by the lack of treatment research addressing serious complex emotional disturbances in youth. Therefore, our scope of services will prioritize those treatments with established effectiveness, including those found effective for similar problems in different patient populations (including the adult literature, when applicable).

An evidence model of care is dependent upon evidence-based practitioners. The CSTC professional staff strives to maintain the following set of clinical skills and principles: 1) the ability to synthesize complex presentations, and identify targeted areas where effective intervention is most likely to succeed; 2) the ability to critically examine the literature, and extract relevant strategies and techniques; 3) the ongoing desire to learn and adopt new skills and treatment modalities; and 4) the willingness to use effective strategies based on patient needs, rather than adherence to past training or theoretical beliefs.

Psychopharmacology

Psychotropic medications are an important part of the treatment armamentarium for serious child and adolescent psychiatric disorders. However, although the research base is improving, there remains a paucity of literature examining complicated medication protocols for youth with complex disorders. Thus, clinicians must often rely on clinical experience and/or adult literature. The lack of clearly defined standards or protocols creates the situation where almost any type of medication trial or regimen can be justified, and potentially leads to idiosyncratic prescribing habits and/or widely varied practices across clinicians and communities. Furthermore, strategies based on the adult literature presume developmental continuity of the disorder. Although warranted in many cases, this assumption needs to be carefully examined given the difficulty at times extrapolating adult diagnostic criteria for children.

The best studied psychotropic medications for youth are stimulant medications for ADHD (MTA Collaborative Group, 2004), fluoxetine plus CBT for major depression (March et al., 2004), risperidone for behavioral disturbances in youth with autism (McCracken et al., 2002), fluvoxamine for childhoods anxiety disorders (RUPPS, 2001), and SSRI's for obsessive-compulsive disorder (AACAP, 1998). There is some evidence supporting the use of stimulants, alpha agonists, lithium, valproate and antipsychotic agents for aggression (McClellan and Werry, 2004).

Regardless of medication choice and indication, there are standard prescribing guidelines that should be followed:

- Obtain informed Consent from youth and guardians
- Adequately characterize targeted symptoms and monitor their course with treatment
- Agents are generally selected based on the strength of evidence supporting its use, safety considerations, history of treatment response and family/child preference. If one agent in a class is FDA approved for a psychiatric indication in children, it is reasonable to consider that medication first. Furthermore, if a class of agents (e.g.,

stimulants) are well studied for a particular indication (e.g., ADHS), it is preferable to try different agents within that class before switching to alternative, less evidence-based options.

- In general, start low, go slow, reach an adequate dosage, and maintain the same agent, if tolerated, for a sufficient time to determine whether the agent is effective. Other than stimulants, most agents require 4-6 weeks to work. Frequent medication changes and/or adding multiple agents over short periods of time leads to complicated polypharmacy regimens without clear evidence as to which agents are helpful.
- Choose one agent that addresses multiple symptoms/disorders, rather than one for each.
- Not every reported symptom represents a syndrome, or an indication for medication.
- In general, the underlying primary disorder should be treated first before adding adjunctive agents for secondary symptoms/diagnoses.
- Avoid excessive polypharmacy. The long-term treatment provided at CSTC allows complicated medication regimens to be systematically reevaluated over time.
- Avoid prn agents. If medications are needed to help control problems with thinking, mood or behavior, they are more effective given on an ongoing basis rather than as needed. For many of our clients, providing prns reinforces the use of agitation and aggression as a negotiation skill, since these behaviors force an interaction around the medication. It also reinforces perceptions that the youth cannot manage their own behaviors, and the youth's dependence on external mechanisms to feel safe.

Basic Pediatric Care

Youth at CSTC require basic pediatric care. The CSTC medical staff will either provide directly or oversee these services, as authorized by their clinical privileges. The scope of services includes:

- Physical examinations
- Laboratory monitoring, including basic health care screening and medication monitoring
- Coordinating other basic health care screening, including standard dental, hearing and vision screens
- Assessment and monitoring of psychotropic agents
- Assessment and treatment of common pediatric problems, including otitis media, acne, urinary tract infections and seasonal allergies
- Assessment and referral as indicated for more complicated medical problems requiring specialty interventions (e.g., wound care, surgical consultations, neurology consultations, endocrinology consultations). The CSTC clinician may also provide ongoing care of these problems, with ongoing follow-up as indicated by the community specialist.

Psychotherapy

Psychotherapy remains a mainstay of psychiatric treatment. Unfortunately, the existing evidence suggests that the widely used traditional psychotherapies are not effective in youth (Weiss et al., 1999, 2000; Weisz and Jensen, 2001). The best-supported psychotherapy interventions in youth are based on learning and behavioral principals (Wiesz et al., 2005), including cognitive behavioral therapy (CBT), parent-training and psychoeducational strategies. CBT strategies have been found to be helpful for depression, anxiety disorders, posttraumatic stress disorder and conduct problems (Compton et al., 2004; Cohen, 2003; Kazdin, 2000, Smith e al., 2007). Interpersonal psychotherapy has also been shown to be beneficial for adolescent depression (Mufson et al., 2004). Parent training programs have been developed to improve parent-child interactions, enhance parenting effectiveness and reduce coercive interactions (Brestan and Eyeberg, 1998).

There are interventions primarily studied in adults that hold promise for youth. Dialectical behavior therapy (DBT) is a cognitive behavioral psychotherapy with documented

effectiveness for reducing parasuicidal behavior (any deliberate self-harm behavior including suicide attempts) in women with borderline personality disorder (BPD) (Linehan, 1993). DBT has been adapted as a treatment of adolescent inpatients (Datz et al., 2004; Rathus & Miller, 2002; Woodberry, 2002), and incarcerated teenage girls (Trupin et al., 2002). DBT Family interventions have also been developed (Miller, et al., 2002). Motivational interviewing for substance abuse therapy is another promising intervention (Grenard et al., 2006).

At CSTC, the following psychotherapy practices or principals will be followed:

- The development and adaptation of evidence-based psychoeducational individual and group therapies to address basic self care, problem-solving, treatment planning, communication, and relapse prevention
- The development and adaptation of evidence-based cognitive behavioral and interpersonal strategies to address mood and anxiety symptoms, posttraumatic reactions, mood and behavior regulation, coping strategies and interpersonal effectiveness
- The development and adaptation of evidence-based skill building strategies to improve negotiation strategies, mood and behavioral regulation skills, coping and effectiveness
- The development and adaptation of evidence-based interventions for specialty populations, e.g., the use of DBT for individuals that engage in self-harming behavior, motivational interviewing for substance abuse, and trauma focused CBT.
- The development and adaptation of evidence-based family based interventions, e.g., multifamily group therapy, designed to enhance parenting effectiveness, improve family communication and/or empower families to better care for, and advocate for, their child.
- The adoption of milieu based therapeutic models designed to teach and reinforce effective behavioral and self-regulation strategies, while not reinforcing negative or coercive negotiation styles or behaviors (e.g., Positive Behavior Support).

System of Care

Youth at CSTC are often involved with multiple systems of care, including mental health, educations, juvenile justice and/or social welfare, and require the provision of coordinated services. Effective models have been developed. For example, multisystemic therapy (MST) (Henggeler et al., 2002; 2003) utilizes aggressive case management, comprehensive psychiatric services and targeted family interventions to maintain seriously impaired youth in their homes and local communities. These models are based on principals (e.g., family centered care, maintaining youth in their homes and communities,) yet ultimately depend upon what services are provided, and the training and skills of clinicians providing the care.

Effective discharge planning requires the provision of coordinated effective services to aid transition of youth back to the community, and decrease the risk for rehospitalization. CSTC will advocate for comprehensive community services as part of our treatment planning. We will facilitate communication and case planning across the different involved systems, and provide consultation and advocacy for youth and families after they work to successfully return to their communities.

Leadership and Workforce Issues

A critical need for implementing evidence based care is team leadership. The CSTC professional staff will design and implement effective treatment plans, and teach and model these approaches for families, child care counseling staff, and community providers. Furthermore, our training and education efforts will maintain a focus on evidence-based comprehensive effective treatment.

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